Patient Information Form

Today's Date__________

Name____________________________________ Sex M F (circle one) DOB______________ Age________

Circle one: Single Married Separated Widow SS#______________________________________

Home #_______________Cell #__________________Email____

Home Address_________________________________City________________________Zip______________

Place of Employment______________________________ Occupation_______________________________

Spouse/parent name_____________________________________ Phone #____________________________

Emergency contact ______________________________________ Phone #___________________________

Primary physician____ Phone #___________________________

General Dentist ____ Phone #___________________________

Reason for your visit ____

How did you hear about our office?____

Insurance Information

Primary

Insured name_____________________________

DOB_______________

Insured's Employer_________________________

Insured's SS#_____________________________

Insurance company_________________________

Phone #__________________________________

Member ID_______________________________

Group #__________________________________

Secondary

Insured name_____________________________

DOB_______________

Insured's Employer_________________________

Insured's SS#_____________________________

Insurance company_________________________

Phone #__________________________________

Member ID_______________________________

Group #_________________________________

Dental History

Date of last dental cleaning/checkup__________________

How often do you receive dental cleanings?_________________

Do you:

Clench or grind your teeth? Clench Grind (circle one or both)

Use tobacco products, which kind and how much?____

Drink alcohol, how much/how often?____

Have you had:

- Gum surgery
- Periodontal scaling (deep cleaning/date)
- Bleeding gums after brushing
- Any teeth shifting recently
- Orthodontics/braces
- Serious injury/blow to mouth
- Wisdom teeth removal

When? ___________

Medical History

Date of last physical exam________________________ Height__________ Weight__________

Please check if any of the following applies to you:

- AIDS
- Allergies (seasonal)
- Anemia
- Angina
- Arthritis
- Artificial heart valve
- Artificial joints
- Asthma
- Blood thinner use
- Blood disease
- Bruise easily
- Cancer
- Chemotherapy
- Cortisone medication
- Diabetes
- Dizziness
- Drug addiction
- Emphysema
- Excessive bleeding
- Fainting
- Glaucoma
- Heart condition
- Heart murmur
- Heart surgery
- Hepatitis or liver disease
- High BP
- HIV +
- Kidney disease
- Low BP
- Pacemaker
- Psychiatric treatment
- Respiratory problems
- Schizophrenia
- Seizures
- Stomach problems
- History of stroke
- Thyroid disease

Any illness not listed? ____

Do you have any of the following **drug allergies**?

- Aspirin
- Local anesthetic
- Tetracycline
- Codeine
- Erythromycin
- Penicillin
- Sulfa
- Latex
- Other_________

If female, are you now: (circle yes or no)

Pregnant? Yes No Taking birth control pills? Yes No Through Menopause? Yes No

Please list **ALL** medications currently in use, including vitamins and homeopathic medication:

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Patient or guardian's signature________________________________ Date________________

Doctor's signature__________________________ ASA category_________ Date____________